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INSTITUTE OF ALMONERS

REPORT OF A SURVEY OF

CONVALESCENT FACILITIES IN

ENGLAND & WALES.

CANCELLED

June 1947.

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MEMBERSHIP OF CONVALESCENT HOMES COMMITTEE

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Miss L.B. Adams, Almoner, Hospital for Sick Children, Great Ormond Street, W.C.1.

Miss J. Buck, Almoner, Cumberland Infirmary, Carlisle.

Miss S.R. Brown, Almoner, General Infirmary, Leeds.

Miss K. Buchanan, Almoner, Royal Surrey County Hospital, Guildford.

Miss M. Davidson, Almoner, County Hospital, Whiston, Prescot, Lancs.

Miss A. Keen, Almoner, Royal Infirmary, Glasgow.

Miss S. King, Almoner, Municipal Hospital, Brighton.

Miss K. Luce, representative from Family Welfare Association, 296 Vauxhall Bridge Road, S.W.1.

Miss E.B.C. Powell, Almoner, Southmead Hospital, Bristol.

Miss M.J. Roxburgh, Almoner, Middlesex Hospital, W.1.

Mrs. R. Sainsbury.

Mrs. Southall.

Miss K. Tilbury, County Welfare Officer, Northumberland B.R.C.S. (to April 1947).

Miss A.E. Turner, Almoner, Radcliffe Infirmary, Oxford. (from April 1947).

Mrs. Vaughan Smith, Psychiatric Social Worker, Harrison Hospital, Dorchester. (to March 1946).

MISS E.C. WARREN, ALMONER, HAMMERSMITH HOSPITAL, W.12.

Miss C.M. Wyatt, representative from British Red Cross Society, 14 Grosvenor Crescent, S.W.1.

Miss Wynne, representative from Invalid Children's Aid Association, 4 Palace Gate, W.8.

Miss S. Nutt, Assistant Almoner, St. Thomas' Hospital, S.E.1. (Hon. Secretary - resigned October 1946).

Mrs. I. Boag, Assistant Almoner, Royal Free Hospital, W.C.1. (Hon. Secretary - from October 1946).

THE INSTITUTE OF ALMONERS

Report on convalescent facilities in England and Wales

The Institute of Almoners has, for some considerable time been closely interested in the facilities available for the convalescent patient, as arrangements for convalescent treatment are the recognised responsibility of Almoners in practically all hospitals. A committee was therefore set up in July 1945 to consider the whole problem. Convalescent homes in Great Britain have developed without co-ordinated planning and without supervision, and it has never been possible to obtain complete information about the number and types of homes in the country. After the end of the war, during which so many homes disappeared or were diverted to other uses, the Committee felt that a survey of the existing facilities would be of great value. This has been undertaken for England and Wales and a similar survey is in process for Scotland.

One of the first difficulties in approaching the question of convalescent homes is the definition of the term "convalescence". Many attempts have been made from time to time without complete success, but it is generally agreed that, broadly speaking, a convalescent home admits patients who have passed the acute stage of their illness, but still require some medical or nursing supervision during the later stages of their recovery. The object of such homes is to facilitate recovery in an atmosphere as close to that of normal life as possible. Convalescent homes are also valuable for patients suffering from certain chronic conditions of chest, heart etc., as it is frequently found that the general condition of the patient is improved and temporarily relieved by a short stay at such a home.

It has been found that little account can be taken of the designation which homes give themselves and some which call themselves convalescent hospitals are in fact homes for ambulant patients: one convalescent hospital, for example, with 200 beds, has a nursing staff of two and undertakes practically no treatment of any kind. The Committee has not concerned itself with homes to which patients go a few days after operation while still bed-fast, and which might more properly be called pre-convalescent hospitals.

No systematic survey has been made, or account taken of private convalescent homes run for profit, which are registered as Nursing Homes under sections 187 ff. of the Public Health Act 1936. It is not thought that the number of these taking only convalescent patients is very large, but there is a persistent demand for this type of home and the present methods of supervision do not appear to be entirely satisfactory despite legislation. A few general convalescent homes have a small number of private rooms where the charges are a little higher than the usual, ranging from £2.10.0. to £4.4.0. or more, but the total of such beds is very small.

Apart from these, all types of homes have come within the purview of the Committee from those in which medical, nursing and other staff give a certain amount of treatment, to the holiday type of home which has in some cases no nursing staff and gives only a minimum of medical attention, but which takes hospital patients requiring rest, sometimes as a preventive measure.

ERRATA.

The following amendments should be made to the figures given for the Bristol region in the tables in this section:-

Table I.	No. of Homes.	Approx. no. of beds.
	43	1,320 (delete "in 25 homes visited")
(This alters totals to:-	318	14,190)

Table II.	M & W.	M.	W.	Chil.	M & b.
	8	7	18	9	-

Table III.	-25	25-49	Smallest
	83	15	8 (delete "homes visited only")

Table IV.	Vol. Cttee.	Social Agency	Rel. Grp.	Vol. Hosp.	Local Auth.
	19	4	6	2	1

The method used in the survey has been to arrange for the visiting of all convalescent homes known to, and used by Hospitals whether they belong to voluntary bodies, Hospitals, or Local Authorities, and for reports to be made to the Central Committee. In order to ensure uniformity, a report form was drawn up asking for details of bed numbers, staffing, treatment given, routine and amenities. As a result 270 visits have been paid so far (June 1947) and very valuable information obtained. Unfortunately in 12 cases the visitors were refused admission to the homes. In some cases difficulties of transport and situation have made it very difficult for visits to be paid but almoners have performed a difficult and arduous task with great vigour.

Homes which are closed have not been visited. An attempt was made in the area of the four London regions to discover what had happened to the many homes which had disappeared, but with very disappointing results. In this area, where the Committee has been working closely with the King Edward's Hospital Fund, any information available has been passed on to that body which, it is hoped, will meet with greater success. It is not, unfortunately possible to give any accurate figures about the number of homes closed, during and since the war, but it is thought that the total is over 120, by far the largest proportion being in the South coast area. Though some are reopening, the process is very gradual and many appear to have been diverted to other uses, such as nurseries, maternity homes, hospital annexes and even emergency training colleges for teachers.

A. DISTRIBUTION OF HOMES

Table I. Regional distribution of Homes (see also map at end of report).

Region.	Number of Homes	Approximate no. of beds
North Eastern	9	420
Leeds	18	850
Sheffield	14	610
Cambridge	6	360
London N.E.	9	340
" S.E.	62	3200
" N.W.	20	560
" S.W.	53	2040
Oxford	7	200
Bristol	51	(930 in 25 homes visited)
Wales	21	1090
Birmingham	11	540
Liverpool	18	1110
Manchester	26	1550
Total:	326	13800

This table includes all homes known to be open in June 1947 and used by Almoners for convalescent patients.

A survey by Miss E. Gardner of New York in 1930 gave the total of convalescent homes in Great Britain as 431, but in this number were included many which can be regarded as hospitals, such as Queen Mary's Hospital, Carshalton, and the Spa Hospitals. The P.E.P. report on the British Health Services (1937) gives no

definite figure but estimates the number of homes at between 400 and 500. The list which has now been compiled is more comprehensive than any published list to be found in the Hospital Surveys, Charities Digest and other publications. It is thought that it includes practically all homes but the figures show a most regrettable drop in numbers from pre-war level. Even before the war the number of homes then existing was regarded as falling short of requirements and present conditions make the need even more urgent. Estimates of the needs have been made from time to time but all have been quite arbitrary, and it does not seem possible to give any reliable figure at present. Much depends on the development in the use of convalescent treatment, the value and possibilities of which are perhaps not yet sufficiently widely recognized. It is interesting to note that in a recent survey of the demand for rehabilitation and convalescent treatment by the Liverpool Hospitals Joint Advisory Committee it was estimated that organized convalescent home treatment was required for 50% of surgical cases, 45% of gynaecological cases, 30% of medical cases and a smaller percentage of orthopaedic cases.

The geographical distribution is of interest, (see map) most homes being situated, as might be expected, in the warmer coastal regions of the country, particularly within easy reach of large centres of population. There does, however, appear to be a dearth of homes in Wales. Whilst the accessibility of the Home is important it is found that patients often prefer to go to homes outside their own locality, the seaside being particularly popular.

The region most ill-served by convalescent homes is the North-Eastern, and it is the general opinion of Almoners working in that region that there is a great need for more homes of all types. Patients from this region often have to travel great distances to homes, cases of pulmonary tuberculosis going as far as Torquay, owing to the general shortage. One hospital reports "The chief difficulty is that our homes are too far away for the more seriously ill patients to undertake the journey ..... The numbers sent for convalescence have consequently dropped badly".

Table II. Sexes.

	Men, women & children	Men & Women	Men	Women	Children	Mothers & babies
North Eastern	2	2	1	-	3	1
Leeds	1	6	4	6	-	1
Sheffield	-	3	5	4	2	-
Cambridge	2	1	1	2	-	-
London N.E.	1	-	1	5	2	-
" S.E.	2	11	9	17	22	1
" N.W.	1	5	1	6	5	2
" S.W.	4	3	5	18	20	3
Oxford	-	1	-	1	4	1
Bristol	1	11	6	20	11	2
Wales	-	3	7	6	4	1
Birmingham	-	4	2	2	3	-
Liverpool	-	3	1	5	8	1
Manchester	4	4	6	5	6	1

The lower age limit for boys and girls at adult homes varies, but is usually 12 in the cases of boys or 15 in the case of girls. Some homes taking women also take young boys and girls.

The shortages of homes for all ages and sexes is reported as serious particularly in the summer when waiting-lists are very long. Homes report waiting-lists varying from 3 weeks to over 3 months in the summer, the demand being less during the winter. It is often a great disadvantage that patients cannot, on account of waiting-lists go direct from hospital to a convalescent home. The patient who has to return home to wait for a vacancy at a convalescent home may feel reluctant to make the further change from home to convalescent home and his rate of recovery may consequently be much retarded.

Almoners report that during the summer of 1946 "patients have to wait 6 weeks to two months" (Midlands) "within the last week I have written to convalescent homes.... and have been offered vacancies ranging from June until 31st July" (extract from a letter written 25th April 1946 - South West). On Merseyside waiting-lists appear to be more manageable, but nowhere, except in the middle of winter and the most inclement weather, does it seem at all possible to get immediate vacancies at Homes. For children the shortage of Homes is most grave, and children's hospitals report waiting-lists often months long. The Homes themselves confirm this and further evidence on this point could be given by the Invalid Children's Aid Association who last summer had to close their lists.

Serious shortages exist of homes for mothers and babies, and homes for adolescent boys. Only two homes appear to cater solely for boys in their teens. Some homes for men admit these boys, but this is not considered satisfactory.

There are some homes which are prepared to take elderly patients but the experience of the homes is that it is not satisfactory to mix the young convalescent and the more elderly. There is, perhaps, a tendency for Homes admitting the elderly convalescent to become semi-chronic homes, and in several already one finds convalescent and chronic sick being cared for - often in the same wards. This is not, in the opinion of the Committee, at all satisfactory as the atmosphere in these homes tends to be depressing. A few convalescent homes for elderly patients have been opened in the north west and south east by various voluntary organizations. It seems, though no figures are available, that there is scope for such homes.

Table III. Size of Homes.

	-25	25-49	50-99	100+	Largest	Smallest
North Eastern	2	4	2	1	105	15
Leeds	4	7	6	1	119	10
Sheffield	4	3	6	1	162	13
Cambridge	1	1	3	1	102	10
London N.E.	5	2	1	1	130	8
" S.E.	23	14	13	12	230	8
" N.W.	12	5	2	1	100	8
" S.W.	19	20	11	3	160	4
Oxford	5	1	1	-	65	7
Bristol	10	10	4	1	140	10(homes visited only)
Wales	4	8	6	3	150	8
Birmingham	2	5	3	1	116	8
Liverpool	4	7	3	4	200	7
Manchester	4	11	7	4	174	9

As can be seen the size of homes varies greatly and it does not appear that there is any optimum number of beds per home. As one of the main objects of convalescence is to restore the patient to normal life and not perpetuate the hospital atmosphere it would seem preferable for homes not to be too large and institutional in style, though there are some patients who thrive in the institutional atmosphere.

Table IV. Ownership.

	Voluntary Committee	(1) Social Agency	(3) Religious Group	(2) Organizations connected with trades or professions	Voluntary Hospital	Local Auth.	Hospital Cont. Scheme	(4) Misc.
N.Eastern	2	1	-	2	1	3	-	-
Leeds	5	3	2	2	2	-	3	-
Sheffield	4	1	2	6	-	-	1	-
Cambridge	2	-	-	2	1	-	1	-
London N.E.	5	-	2	-	1	-	-	1
" S.E.	19	11	11	7	8	4	-	2
" N.W.	9	2	1	-	3	4	-	1
" S.W.	23	5	11	4	4	5	-	1
Oxford	3	2	-	-	2	-	-	-
Bristol	23	5	7	8	3	2	3	-
Wales	6	5	-	2	1	1	6	-
Birmingham	4	-	-	3	-	-	2	2
Liverpool	6	6	2	1	-	1	1	1
Manchester	8	3	4	8	-	-	3	-

(1) Includes:- Holiday Funds, National Institute of the Blind, British Red Cross, Ex-Service organizations, Invalid childrens' organizations.

(2) Includes:- Rest-Break Councils, Miners, Police, Manufacturers, Railways, Trade Unions, Nurses.

(3) Includes:- Roman Catholics, Jewish Board of Guardians, Unitarians, National Sunday School Union, Church Army.

(4) Includes:- Friendly Societies, Settlements, City Companies.

Homes run for members of organizations, hospital contributory schemes or certain trades and professions restrict admission to their members but it has not been possible to discover whether this leads to a wastage of beds. Homes attached to hospitals do not always restrict admission to patients who have been in the hospital and are thus able to make use of beds which would otherwise be vacant for some periods.

B. NATURE OF ILLNESSES CATERED FOR AND TREATMENT GIVEN.

Most Homes state that they take "general post-operative and medical cases" and make no definition as to the type of case they prefer. For this reason no classification is really possible. One or two homes in areas particularly suitable for chest complaints express a preference for such cases but there is no apparent tendency towards specialization. At a conference of convalescent

home representatives recently held by the Committee the general view was expressed that as far as possible the variety of types of case taken should be retained. The Diabetic Association has homes specially for diabetic patients where a certain amount of useful educative treatment is given during the convalescent period. Examples of other specialized homes which have recently been opened are the Meath Home for children suffering from bronchiectasis, and the post sanatorium rehabilitation centres of the Middlesex County Council.

There is great need for homes taking more serious cases. The provision for patients with gastric conditions requiring diet is not adequate. Patients needing convalescent care who are heart cases are accepted at only 12 homes. The first home to accept convalescent patients who also suffer from fits is shortly to be opened. It is very difficult to place asthma cases, or patients recovering from pulmonary tuberculosis. There is hardly any provision for skin cases or cancer cases, particularly patients with colostomies, whose general state of health can be much improved by a period at a convalescent home.

The Hospital Almoners' Association pointed out to the Ministry of Health three years ago the shortages of convalescent facilities for the foregoing categories of patients and there is no reason to believe that the position has in any way improved since then. It is, however, unfortunately not possible to assess the exact need, but the opening of even a small number of beds on an experimental basis would no doubt bring the extent of the problem to light.

Of the Homes visited 30 will take patients needing bed-treatment during the first week (most of these are childrens' homes and two approximate closely to hospital-type homes, but have been included as border-line cases), but the majority of homes state categorically that they will not take cases needing bed-treatment or nursing attention at night. If bed cases are to be transferred direct from hospital it is particularly important that the journey to the home should not be a long and tiring one. It is for consideration whether the ordinary convalescent home should take bed-cases, but it is generally felt that this function should be left to intermediary pre-convalescent hospitals as has been suggested on occasions. Apart from medical considerations and accommodation difficulties there are sound psychological reasons for sending patients who are likely to require only a short period in bed during convalescence direct to a convalescent home. However, in this, as in all other aspects of convalescence, flexibility is needed and both types of homes may be required.

Very little treatment of any kind, other than medical supervision, (in over 90% of the cases by a part-time visiting Medical Officer) appears to be given in the convalescent homes reviewed. These visiting doctors are usually local general practitioners who visit the home once a week, or as required. More frequent visits are not usual. The number of homes where any but minor dressings are undertaken is very small (not more than 20% of the total visited) and this is not always due to lack of nursing staff. It does seem from a study of the staff of homes that nursing staff is not always used to the best advantage. This is perhaps largely due to the fact that a number have to undertake domestic duties owing to the shortage of domestic staff, but there are cases of homes which have several nurses on their staff but will not accept patients requiring any

nursing or treatment. The shortage of homes for patients needing post-operative dressings and care of plasters is serious. Resident or part-time physiotherapists are rare, some homes arrange for physiotherapy or ultra violet light treatment at the local hospital, but such arrangements tend to be spasmodic. Occupational therapy is being introduced at 5 homes, chiefly as a form of recreation for psychological reasons.

"The traditional attitude of passive care" noted by Dr. J. Bryant, the American writer on convalescence in 1927 still largely persists and active efforts to make the convalescent period yield the maximum benefit to the patient seem generally to be lacking. This is to a great extent a medical question, but it is to be deplored if the English system of convalescent homes, which was for so long regarded as one of the best in the world, has now fallen below the standards reached in other countries.

Of the homes visited 21 were of the pure holiday type, and 4 were Rest-Break Homes. These do not aim at giving any form of treatment and often have no nursing or medical staff. There is a place for the holiday-type home but it is difficult to know how far such homes are being used at present as substitutes for convalescent homes proper, owing to the shortage of accommodation.

Rest-Break Homes are not so well-known to Almoners in hospitals, as their aim is to prevent illness. They should however be a part of any convalescent scheme, and the decision of the British Hospital Contributory Schemes Association to give convalescent benefit in respect of patients going to such homes as they are an "adjunct of convalescent home treatment" should be noted. It is regrettable that many of the Industrial Rest Break Homes are now closed.

C. ENVIRONMENTAL AND OTHER FACTORS

One of the most important factors in the choice of a convalescent home is its suitability for the individuality of each patient. For this reason, even where hospitals have their own convalescent homes they are in the habit of using a wide variety of other homes as well. The Committee is of the opinion that much could be done to upgrade homes, some of which are run on very out-of-date lines not always with consideration of the welfare of the patient as their apparent first concern.

Buildings are often old and though sometimes well adapted do not always have the modern amenities desirable in convalescent homes. Nor are converted buildings always capable of being run on the most economic lines from the point of view of staff. Of the homes built as convalescent homes, some are old, (one built over 100 years ago) and fall far short of modern standards. Even some of the newer homes would require adaptation if patients were to be admitted in earlier stages of convalescence or requiring any care.

The size of the wards and numbers of beds is determined to a great extent by the size and design of the home, but where the wards are large it is not the general practice to divide them into cubicles. Wards contain as many as 20 beds and can be very institutional in appearance. Single rooms are usually provided

in homes run for "gentlewomen" and the professional classes. Three homes for adults and two for children had no sitting-rooms and in the case of the children no play-rooms. Furnishings in some cases are good; in the bedrooms chests of drawers or individual lockers are provided and there are plenty of comfortable chairs in the living rooms. But there are still many homes which make very inadequate provision for patients' personal belongings and many reports mention the cheerless and bare appearance of the living rooms and dining rooms. The institutional appearance of many dining rooms with long bare tables is clearly to be deplored. The Committee considers that comfort is one of the first essentials of a convalescent home and organizers of the homes should give more thought to this aspect. More consideration too could be given to the use of colour.

With regard to garden space 65% of the homes have large gardens, many having several acres of grounds, but some which are situated in residential districts have only small gardens. Most of the homes have facilities for patients to sit outside and a very few which have virtually no garden are very close to the sea-shore.

It must, however, be emphasised that the value of a convalescent home does not necessarily depend on the building or surroundings. Much of a home's success depends on the way in which it is run, and the attitude of the Matron or Superintendent and the responsible Committee. In the great majority of cases the head of the home is the Matron who is a trained nurse, and only 6 of the Homes visited have lay superintendents. The question of the necessity for the Matron always to be a trained nurse might usefully be considered. It is considered important that the Matron should not try to introduce the hospital atmosphere of extreme tidiness, polish and discipline, which is unfortunately the case in so many instances. These points were made by members of the Curtis Committee when visiting children's homes and apply equally to those for adults.

This Committee considers that there are certain requisites apart from the purely medical and nursing aspects which have an important bearing as aids to recovery.

1. Reception of patients.

A friendly reception for patients is considered to be of great importance. Patients should not be kept waiting about on arrival but should be welcomed with a hot drink or meal - according to the hour of day. It is considered preferable that in many cases they should be allowed to go to bed immediately and in all homes should be allowed where necessary, to spend part of each day in bed during the first few days of their stay.

2. Breakfast in bed and hours of rising.

Breakfast in bed is the rule in only 6 homes. Of the homes visited 48% said they were prepared to give breakfast in bed where required. The hour of rising is usually between 7.30 a.m. and 8 a.m., but varies considerably - in one Roman Catholic home for children the hour of rising is as ealy as 6.30 a.m. and at a children's home in the Midlands 6 a.m. Considering the state of health and stage of recovery of patients it seems reasonable to suggest that hours of rising might be later and more flexible.

3. Rest

Compulsory rest in the afternoons is the rule in less than 50% of the homes visited. It is however generally the rule in children's homes. Some of the homes where rest is not compulsory make arrangements for certain patients to have an hour's rest in the afternoon. It is noted and deplored that at 10 homes at least, patients are not allowed to rest on their beds or go to their rooms during the day. The Committee considers that adequate arrangements should be made for rest in comfortable surroundings; where possible the rest period should be spent out of doors on stretcher beds or comfortable reclining-chairs.

4. Diet.

Frequently complaints are received on account of the food given to patients. The lack of variety is perhaps inevitable at the present time but there seems to be little imagination used in the preparation and serving of food and meal times are not always well spaced. In a number of cases the last meal of the day is early and no hot drink is provided before the patient goes to bed. There seems all too often to be incomplete understanding of dietary requirements for convalescent patients. None of the homes visited employ a dietician, though two have domestic science trained matrons. The difficulties are accentuated by present shortages of domestic staff. It is the Committee's opinion that an advice service on dietetics for the convalescent patient should be made available to all convalescent homes.

5. Length of stay.

Limitation of the length of stay varies. At children's homes there is rarely any limit, the time spent in the home depending on the progress of the patient.

Many adult homes admit patients for two weeks, extending the period where necessary but 20 homes state definitely that stay is limited to two weeks. In the experience of members of the Committee a minimum stay of three weeks is in most cases desirable, and in any case, a definite limitation is undesirable, the aim of a stay at a convalescent home being to discharge the patient as fully restored to health as possible.

6. Occupation for patients.

It has already been noted that only 5 of the homes visited have the services of an Occupational Therapist. In long-stay convalescent homes for children education is usually provided, though this is not yet universal.

The provision of books is considered important. Libraries are reported in 52% of the Homes, though the quality of the books is not always good. One Home reports an arrangement with a Red Cross visiting library, and another is a branch of the County Library. One or two others have special arrangements with local public libraries, but this is the exception rather than the rule, and it is considered that fuller use could be made of such facilities.

The great majority of homes have supplies of indoor games, and some outdoor, such as bowls, and clock golf, but the quality again is varying. A very small number have their own cinema but many Homes are within reach of cinemas and patients make use of these. Patients are sometimes encouraged to arrange concerts and whist drives.

As many of the Homes are very short of domestic staff patients in adult homes are in many cases asked to assist with a certain amount of light domestic work - bed-making and washing-up. Provided due consideration is given to the medical condition of the patient and there is adequate supervision, there seems to be little objection to this practice, though it has on occasion led to abuse and complaints. Six homes report that patients are allowed to help with a little gardening if they so desire, but no regular use appears to be made of this form of occupational therapy. It is considered that advice on forms of occupational therapy suitable for the convalescent patient might usefully be given to homes.

7. General atmosphere.

A happy atmosphere is an essential aid to recovery in convalescent homes. Rules should be as few as possible. Unfortunately many homes still have long lists of rules of a quite forbidding nature couched in minatory tones. When questioned about rules many matrons said that they do not still hold, and agreed that certain were very much out of date. This Committee would recommend that rules should be revised and made as few and as simple as possible. Rules such as those forbidding men and women in the same homes to meet or go out together should be abolished. Rules regarding the entry of patients into public houses need revision in view of present-day custom.

Informality and the avoidance of institutionalism should be a main aim of a Home. Some homes keep suggestion books and this practice might be extended.

The convalescent period is one of adjustment and restoration to a state of health where patients can adequately bear the stress and strain of conditions of normal life and every effort should be made to help patients to adjust themselves whilst they are at the home. It is important that there should be a strong link between the chief resident officer of the home and the almoner sending patients, and that the almoner should be kept informed and give help and advice where problems arise which prevent patients from getting the maximum benefit from their stay at a convalescent home.

D. ORGANIZATION OF THE CONVALESCENT SERVICE

As a result of the haphazard growth of convalescent facilities the service has up to now been unco-ordinated and unscientific. This, it is hoped, is about to be remedied, but the Committee wishes to emphasise the importance of retaining the individuality of the convalescent home and the need for flexibility. It is not considered desirable that each Home should be limited to take patients from the region in which it is situated or necessarily from one particular hospital. It is important that what facilities exist should be used to the best advantage and many of the serious defects in provision might disappear if the service were properly co-ordinated. The establishment of central bed bureaux for returns of bed-states should ensure the most economical use of beds, though it must again be emphasised that consideration has to be given to the individuality of the patient in choosing a convalescent home and beds cannot be allocated indiscriminately. The establishment too, of some central body to advise and help homes on every aspect of organization would be of the greatest assistance in promoting a more efficient service which is a very important part of an efficient and comprehensive Health Service.

Summary of Recommendations.

I. There is a need for more convalescent homes, the North East appearing to be particularly ill-served for all types.

Shortages are particularly acute in cases of:-

1) Homes for (a) mothers and babies.
   (b) children.
   (c) adolescent boys.
2) Homes taking patients suffering from:-
   (1) severe heart trouble.
   (2) asthma.
   (3) pulmonary tuberculosis.
   (4) other chest complaints.
   (5) fits.
   (6) skin diseases.
3) Homes which undertake the more complicated forms of treatment, dressings and diets.

II. There is a place in the Health Scheme for the Holiday and Rest-Break type of home beside the home giving more active treatment.

III. Alterations and adaptations are required to bring many homes up to modern standards. More attention should be paid to comfortable and cheerful furnishings.

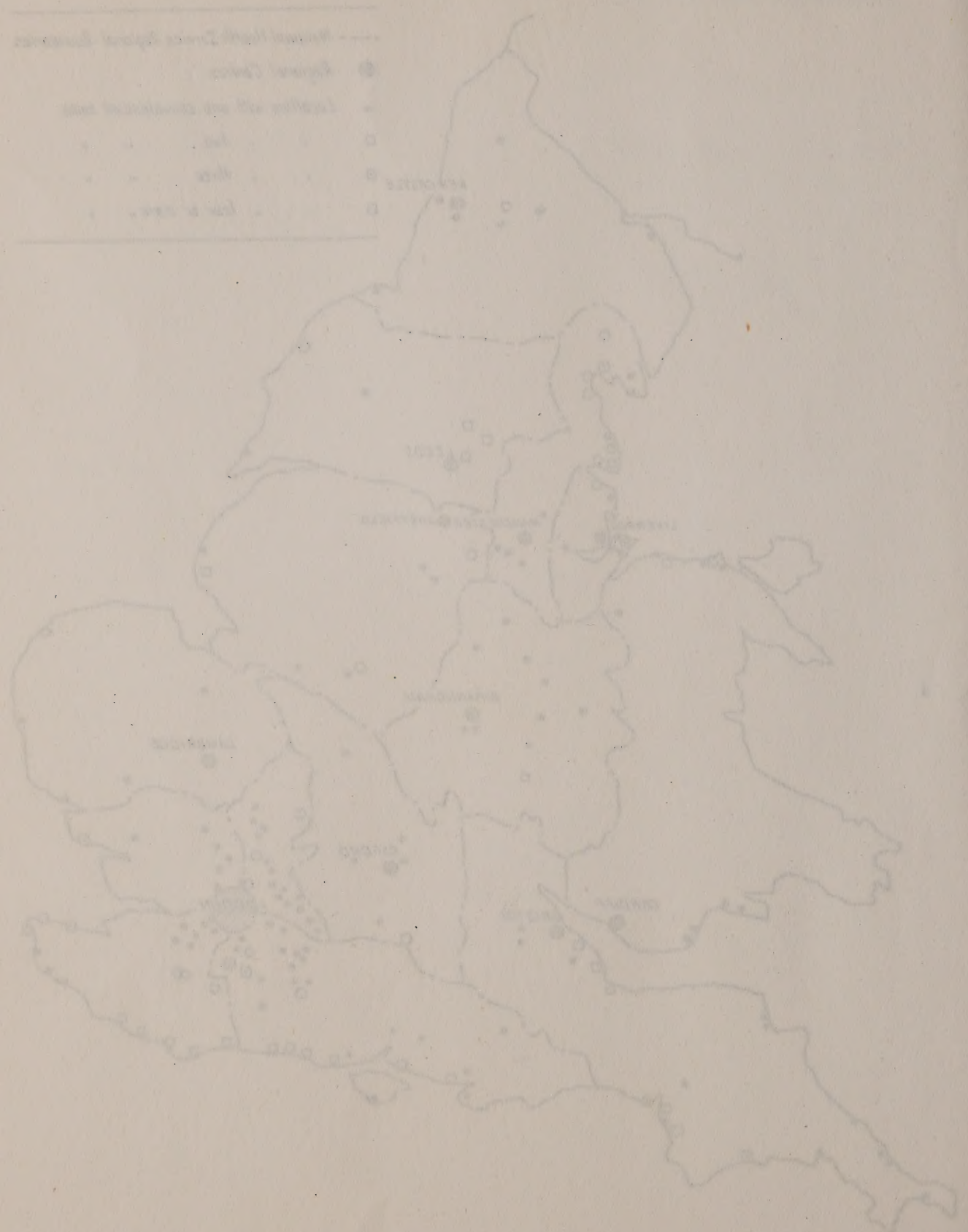
IV. The institutional atmosphere should be discouraged and normal home-like conditions aimed at.

V. With regard to routine:-

1) Special emphasis should be laid on a friendly reception of patients and arrangements should be made where necessary for them to spend part of their first week in bed. The mixing of what are likely to be long-term bed cases and ambulant patients is not generally recommended on account of the psychological effect of the prolongation of the hospital atmosphere.
2) Breakfast in bed should be provided more often than at present as a matter of course and hours of rising should be later.
3) There should be adequate facilities for rest both indoors and in a garden or on a verandah.
4) The medical and social aspects of the case should be the sole considerations in determining length of stay at a convalescent home.
5) More attention should be paid to diet and expert advice made available.
6) Rules should be as few as possible.
7) More consideration should be given to the occupation and recreation of patients. Up-to-date library facilities, education for children and the services of occupational therapists where necessary should be extended. A closer application of rehabilitation methods - almost non-existent in the ordinary convalescent home at present - might be considered.

VI. The whole convalescent service should be more closely co-ordinated, but without loss of individuality and flexibility. (It is important that the present freedom of choice of homes for patients should be maintained). There should be a central advice service on all aspects of organization and staffing, and centralized information about bed-states in homes should be available. There is urgent need for the establishment of standards for convalescent homes, and all homes should be inspected regularly.

Map showing the Geographical Distribution of Convalescent Homes in England and Wales June 1947.



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